

Menopause

Health
professional **tool**

Assessment & management

Menopausal stages

- Regular cycles
 - 'premenopause'
- Change in cycle frequency/flow
 - 'early perimenopause'
- Cycles > 60 days
 - 'late perimenopause'
- Final menstrual period
 - 'menopause' (average age 51 years)
- No menstrual cycles >12 months
 - 'postmenopause'

Based on symptoms only. Hormonal screening unreliable due to unpredictable fluctuations. FSH levels helpful in young women <45 years.

Common menopausal symptoms:

- Hot flushes
- Night sweats
- Muscle/joint pains
- Anxiety
- Irritability
- Sleep disturbance
- Lessened concentration
- Vaginal dryness
- Painful intercourse
- Fatigue
- Crawling sensations on skin
- Overall diminished wellbeing
- Low libido

Screening at midlife

Menopausal women are at increased risk of:

- **Cardiovascular disease.** Assess for thyroid disease, type 2 diabetes, iron deficiency, metabolic syndrome. Monitor BP, lipids, blood glucose, waist circumference and weight. Discuss physical activity and nutrition guidelines.
- **Osteoporosis.** Evaluate risk (see bone health section).
- **Mood disorders.** Ask about depression/anxiety symptoms (see emotional wellbeing section).

Also assess:

- **Heavy or abnormal bleeding.** Investigate for iron deficiency and gynaecological pathology.
- **Cervical screening test, breast examination and mammogram.**
- **Risky behaviours.** Assess alcohol intake and smoking.

Key messages

- Identify a woman's individual concerns during menopausal transition and address specifically, e.g. hot flushes, weight issues, sexual issues or emotional wellbeing.
- MHT is the most effective treatment for distressing symptoms of menopause.
- Body identical, TGA approved, MHT (transdermal or oral estradiol in combination with oral micronised progesterone) provides proven benefits and maximum safety.
- Non-hormonal pharmacological treatments or other therapies may be appropriate due to contraindications to MHT or if the patient does not want MHT.
- Vaginal/bladder symptoms respond to local treatment that may be required in addition to systemic MHT or other therapies (see vaginal/bladder section).
- General wellbeing should be addressed at this time including nutrition and weight management, physical activity, emotional health, and stress management – movement, mindfulness, social connectedness.
- Compounded bioidentical therapy is not recommended due to safety and quality concerns.

Menopausal Hormone Therapy (MHT) candidates

- Women experiencing distressing menopausal symptoms (peri or postmenopause)
- Women with early or premature menopause (bone sparing and reduces CVD risk)
- Women with osteoporosis <60 years
- Women within 10 years of last period for vasomotor symptoms

In general: use lowest effective MHT dose for relief of menopausal symptoms, except in early/premature menopause (see below). Effectiveness monitored by self-reported symptom control.

Contraindications for MHT

(consider referral to menopause specialist)

- Breast cancer (hormonally sensitive)
- Thrombophilia/past venous thrombo-embolic event (VTE)
- Undiagnosed vaginal bleeding
- Active liver disease
- Uncontrolled hypertension
- CVD risk or disease

Alternatives to MHT

| Pharmaceutical | Dose |
|------------------|------------------|
| • Escitalopram | 10-20mgs daily |
| • Venlafaxine | 37.5-75mgs daily |
| • Desvenlafaxine | 50-100mgs daily |
| • Paroxetine** | 7.5-10mgs daily |
| • Gabapentin | 300-900mgs daily |
| • Clonidine | 50-150mcg daily |

** (not to be used with Tamoxifen)
Black cohosh may be useful for mild symptoms.

Women with a uterus: important to note that MHT is not a contraceptive

Early (<45 years)/ premature (<40 years) menopause

High dose, long-term therapy required until at least the age of 50 (unless contraindicated).

Options:

1. Continuous oestrogen (high dose oestrogen due to age) + cyclical or continuous progestogen
2. Combined contraceptive - 17 beta oestradiol most effective
3. Tibolone

Menopausal transition

Lowest effective dose monitored by self-reported symptom control.

Options:

1. Low dose combined contraceptive (if low CVD risk & <50 years)
2. Continuous oestrogen + cyclical progestogen 10-14 days each month + contraception (including barrier, sterilisation)
3. Continuous oestrogen + levonorgestrel IUD for progestogen and contraception

Postmenopause

Lowest effective dose monitored by self-reported symptom control.

Options:

1. Continuous oestrogen + continuous progestogen (if menopause >1-2 years ago)
2. Continuous oestrogen + cyclical progestogen (if menopause <1 year ago) **or** levonorgestrel IUD
3. Tibolone (if menopause is >1-2 years ago)
4. Tissue-selective oestrogen complex (TSEC)

Review: initially 2-6 months then assess benefits/side effects, address concerns, titrate regimen to suit the individual woman – assess need, new development/options, CVD and breast cancer risk. Then annual review.

Vaginal/bladder symptoms:

- Vaginal oestrogen cream, pessaries or tablets.
- Select vaginal lubricants and moisturisers similar (in pH and osmolality) to natural vaginal secretions, less likely to cause irritation.
- Vaginal lubricants (for use during intercourse) eg Astroglide®, KY® Jelly, pjur® and Yes®. May use natural oils e.g. olive, sweet almond oil.
- Vaginal moisturisers (regular, twice weekly use): Replens®, Yes®.

Special considerations

After hysterectomy

Continuous oestrogen or tibolone.

Cancers – breast/endometrial/ovarian (hormone-sensitive) cancer

Liaise with treating oncologist/gynaecologist. In specific cases MHT/tibolone may be used +/- vaginal oestriol for vaginal/urinary symptoms.

Cardiovascular disease (hypertension, diabetes, hypercholesterolemia)

Transdermal MHT.

Endometriosis

OCP, levonorgestrel IUD + oestrogen, tibolone, continuous combined MHT.

With post-surgical menopause need to consider added progestogen/tibolone.

Fibroids

MHT may increase size – less likely with tibolone or transdermal oestrogen and progestogen.

Hirsutism

Oral oestrogen to increase SHBG: cyproterone, dydrogesterone, drospirenone or oral progesterone. Can also use spironolactone.

Low libido

Not OCP or oral oestrogen. Check other drugs affecting libido eg SSRI/SNRI. Use transdermal oestrogen to lower SHBG. Consider tibolone, or testosterone. (See Testosterone Therapy).

Liver disease, gallstones

Transdermal MHT.

Mastalgia

Lower dose, transdermal oestrogen, tibolone, TSEC, testosterone, evening primrose oil.

Migraine

Transdermal oestrogen and progestogen, lower dose, avoid oral progestogens; continuous therapy, not cyclic.

Obesity/morbid obesity

Transdermal MHT.

Progestogen side effect

Change progestogen, tibolone, TSEC.

PV bleeding

Investigate to determine cause and exclude pathology prior to treatment – transvaginal ultrasound +/- hysteroscopy. If atrophic endometrium (<4mm on US), reduce progestin/increase oestrogen. Otherwise, increase progestin dose/length/type. Levonorgestrel IUD.

Testosterone therapy

Testosterone 1% cream (for women) is TGA approved for clinically diagnosed hypoactive sexual desire disorder (HSDD) or low sexual desire with distress, when all other causes are excluded. Total testosterone is measured with SHBG to exclude a high level and to monitor dosing.

Varicose veins

Transdermal or tibolone preferred routes of administration.

VTE/thrombophilia

Assess baseline risk; high risk if VTE recurrent, spontaneous, with pregnancy/OCP, family history, smokers. Screen for inherited thrombophilia. If normal and low risk, use transdermal or tibolone. If high risk or inherited thrombophilia, avoid MHT unless anticoagulated. Seek specialist haematological advice re the use of transdermal MHT.

Weight increase

Not related to MHT.

Bone health

Indications for bone density assessment:

- Family history of osteoporosis
- Overactive thyroid or parathyroid
- Malabsorption e.g. coeliac disease, inflammatory bowel disease

- Some chronic diseases e.g. rheumatoid arthritis, chronic liver or kidney disease
- Corticosteroid use or exposure
- Some medicines for breast cancer and epilepsy and some antidepressants

Osteoporosis

T-score below -2.5

Rx aim: prevent further bone loss and fracture

Plain x-ray thoracic lumbar spine to exclude compression fracture

Exclude other causes:

- Calcium, phosphate, vit D, PTH, TFT, LFT, ESR, serum/urine protein electrophoresis, coeliac antibodies
- Use FRAX risk calculator

Regular weight-bearing exercise, optimise calcium intake + vit D levels:

- MHT <60 years
- Tibolone <60 years
- Bisphosphonates
- Raloxifene
- Denosumab
- Monitor bone density, DXA 2 yearly and bone markers

Osteopenia

T-score between -1.0 to -2.5

Rx aim: prevent further bone loss

Plain X-ray thoracic-lumbar spine to exclude compression fracture

Regular weight-bearing exercise, optimise calcium intake + vit D levels

Monitor bone density DXA 2-5 yearly.

Use FRAX risk calculator

If T-score between -2.0 to -2.5 and they are high fracture risk

Refer to specialist for consideration:

- MHT <60 years
- Tibolone <60 years
- Bisphosphonates
- Raloxifene
- Denosumab
- Monitor bone density, DXA 2 yearly and bone markers

Normal

T-score above -1.0

Rx aim: prevent further bone loss and fracture

Regular weight-bearing exercise, optimise calcium intake + vit D levels

Monitor bone density at 70 years or earlier if requested

Assessment of emotional wellbeing in menopausal women

Women experiencing premature or early menopause are at increased risk of depression and anxiety. Routine screening is recommended for this patient group.

Initial screening questions

1. During the past month have you often felt down, depressed or hopeless?
2. During the past month have you had little interest or pleasure in doing things?
3. During the past month have you felt excessively worried or concerned?

Screening tools for depression and anxiety

- Kessler Psychological Distress Scale 10 (K-10)
- Depression Anxiety Stress Scale (DASS-21)
- Patient Health Questionnaire (PHQ9)
- Generalised Anxiety Disorder Assessment (GAD7)

Disclaimer: these are general recommendations that must be modified according to the clinical presentation and desires of each woman after she has been fully assessed and informed of all available options.



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